# DRIVER INSTRUCTOR APPLICATION

MV3112 8/2007 s.343.62 Wis. Stats.

Clear Form

Return to: Wisconsin Department of Transportation
PO Box 7920
Madison WI 53707-7920

Telephone: 608-264-7049
E-mail: dotdrvrtrnschool@dot.state.wi.us

## Section A - Customer - Please print

**Application Type** - Check One

- ☐ Original
- ☐ Renewal
- ☐ Duplicate - Complete front only

Reason for Duplicate

**License Type** - Check all that apply

- ☐ Adult only
- ☐ Under 18 only
- ☐ Adults and under 18
- ☐ Commercial Motor Vehicle (CMV)

* The social security number may be used for purposes authorized by law.

Neatness and accuracy are important since your license will be prepared from the information supplied on this application.

| 1. Applicant Name (First - Middle Initial - Last) | | | 2. Social Security Number * | |
|---|---|---|---|---|
| 3. Current Residence Address | City | ZIP Code | 4. Birth Date | 5. Sex |
| 6. Mailing Address and/or Post Office Box - ONLY if Different from Residence | | | | |
| 7. Current Instructor ID Number | 8. Driver License Number | 9. Expiration Date | 10. State of Issuance | |

11. Are you a WisDOT employee?
☐ No ☐ Yes - Give Division and Bureau:

12. List all driving schools where you will instruct. For each driving school, include ID number, complete address, and telephone number. Attach a separate page if more space is needed.

| YES | NO | |
|---|---|---|
| ☐ | ☐ | 13. In the past 5 years, have you been licensed in another state or Canada? If yes, list location and submit a driving record from there. |
| ☐ | ☐ | 14. Have you been associated with a driver school when its license was revoked, suspended, cancelled or denied? If yes, give school name, reason, date and location. |
| ☐ | ☐ | 15. Are you employed by, or do you have financial interest in a third party tester for CMV? If yes, give third party tester name, address and telephone number. |
| ☐ | ☐ | 16. In the past, have you been convicted of a felony? If yes, give reason, date and location. |
| ☐ | ☐ | 17. Are you required to register with the Sex Offender Registry? If yes, give reason, date and location. |
| ☐ | ☐ | 18. Are you required to register with the Nurse Aide Registry? If yes, give reason, date and location. |
| ☐ | ☐ | 19. Have you had any instructor license revoked, suspended, cancelled, or denied? If yes, give reason, date and location. |
| ☐ | ☐ | 20. In the past year, have you had a loss of consciousness or muscle control, caused by any of the following conditions? If yes, check condition(s) and give date _____ . |

☐ Brain or Head Injury ☐ Heart ☐ Mental ☐ Seizure Disorder ☐ Diabetes ☐ Lung ☐ Muscle or Nerve ☐ Stroke

21. I have completed one of the following training programs. Attach copies. (If applying for renewal or duplicate, disregard this question.)
☐ 40 Hour Course ☐ DPI Certification ☐ 9 Credits in Driver Education

22. For renewal only: I have completed the required traffic safety workshop.
☐ Yes, Give Date: ☐ No

23. I certify that the answers and statements on this application are true and correct. I understand that I may be required to submit additional medical information if requested. I also understand that this application will be denied if I have unpaid taxes or child support. I authorize the examining physician to release my medical history upon request to the Wisconsin Department of Transportation.

(Applicant Signature) (Date)

(Over)

Print

## Section B - Medical Practitioner - Please print

Please answer ALL of the following questions regarding the applicant identified on the other side of this form.
**This report must be based on an examination conducted within 90 days of this application.**

Examination Date - Required

| YES NO | YES NO | YES NO |
|---|---|---|
| ☐ ☐ Alcohol or other drug abuse or dependency within the past 12 months | ☐ ☐ Heart surgery (valve replacement/bypass, angioplasty, pacemaker, AICD) Date _____ | ☐ ☐ Positive TB in a communicable form |
| ☐ ☐ Alcohol or other drug abuse or dependency within the past 12 - 24 months Controlled by treatment ☐ Yes ☐ No | ☐ ☐ Mental/Emotional Functions | ☐ ☐ Missing or impaired hand, arm, foot, leg |
| ☐ ☐ Blood pressure over 180/105 | ☐ ☐ Diabetes or elevated blood sugar controlled by ☐ Diet ☐ Pills ☐ Insulin | ☐ ☐ Seizures, epilepsy Episode Date _____ |
| ☐ ☐ Heart disease or heart attack, stroke, other cardiovascular condition | ☐ ☐ Kidney disease, dialysis | ☐ ☐ Neuro/Muscular disease, e.g., ALS, MS, Head Trauma |
| | ☐ ☐ Lung disease, emphysema, asthma, chronic bronchitis | ☐ ☐ Loss of, or altered consciousness Date _____ |
| | ☐ ☐ Required oxygen use | ☐ ☐ Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring |

For any YES answers, indicate onset date, diagnosis, and any current limitations. List all medications (including over-the-counter medications) used regularly or recently.

Yes ☐ No ☐ The individual who is requesting this physical is applying to become a licensed driver training school instructor. In a vehicle, he/she may be instructing, at the same time, up to 3 students that may be under the age of 18. Do you believe this person is physically and mentally capable to act as a driver instructor?

| Name of Medical Practitioner - Please Print | Medical License Number |
|---|---|
| Identify Medical Practice | Area Code - Office Telephone Number |

**I certify that I have examined this applicant, that the above answers are a result of the examination, and that I am licensed to practice in Wisconsin.**

Signature of Reporting Medical Practitioner — Date

**X**

## Section C - Cooperative Driver Training Program (CDTP) or DMV Use

| School Name | School ID # | Instructor Name | Instructor ID # |
|---|---|---|---|
| | | | |

| Knowledge Tests - 80% or Higher to Pass | Highway Signs | Driver Training Instructor Test | Class D |
|---|---|---|---|
| | ☐ Pass ☐ Fail | ☐ Pass ☐ Fail | ☐ Pass ☐ Fail |

## Section D - DMV Use Only

| CDL | Skills Test (MV3543 or MV3544) | Oral (MV3222 or MV3717) |
|---|---|---|
| ☐ Pass ☐ Fail | ☐ Pass ☐ Fail | ☐ Pass ☐ Fail |

**Brake Reaction Results** Average of 3 times: At least 50/100 second using portable test ☐ Pass ☐ Fail **OR** During Skills Test - 1 time ☐ Pass ☐ Fail

Visual Acuity - 20/40 in one eye (either one) and at least 20/100 in other eye; Temporal Field of Vision of **at least 85°** in EACH eye

| | Without RX | With RX | Temporal Field | Normal Color Perception |
|---|---|---|---|---|
| | | | | ☐ Yes ☐ No |
| Right Eye | 20/ | 20/ | ≥ 85° ☐ Yes ☐ No | 20% Minimum Depth Perception - Able to see sign closest to eye ☐ Yes ☐ No |
| Left Eye | 20/ | 20/ | ≥ 85° ☐ Yes ☐ No | Hearing - Must be normal ☐ Corrected ☐ Uncorrected |

COMMENTS

| Date | Place of Examination | Examiner Signature / ID # |
|---|---|---|
| | | |

## Section E - DTS Coordinator Use Only

Driver Record Check

Background Check ☐ CIB ☐ JUS ☐ CCAP ☐ SOR ☐ NAR